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## **Narratives of illness and offending: mentally disordered offenders' views on their offending.**

### **Abstract**

Narratives have been used in both the sociology of health and illness and in criminology to examine how groups of people present themselves in moral terms. This article focusses on the narratives of offenders with mental health problems in England subject to section 37 / 41 of the Mental Health Act 1983 to examine how they justified offending prior to admission. Participants presented illness in a variety of different ways indicating a range of moral positions towards offending. In line with previous research a first group used mental illness to excuse offending and saw themselves as achieving moral reform through treatment. A second group also used illness to excuse offending, but did so inconsistently, seeking to mitigate responsibility whilst distancing themselves from treatment obligations. A third group portrayed themselves as dishonourable both due to their category of offence and the type of illness experienced. A final group rejected both labels of illness and offending, seeking to portray themselves as consistently moral.

[Abstract word count – 161].

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### **Introduction**

Mentally disordered offenders pose a problem for the criminal justice system. Courts are tasked with deciding whether an individual has committed an offence and how far they should be held responsible. However, mental disorder may limit an individual's ability to understand or weigh up the consequences of their actions making notions of responsibility problematic. This paper is about how a group of individuals, identified by the courts as needing psychiatric treatment due to their

level of risk toward others, viewed their offending behaviour. Through studying their narratives I examine how attitudes towards illness affected notions of responsibility.

Courts in Europe and the United States have developed different ways of judging the level of responsibility mentally disordered offenders should hold through criminal or mental health laws (Hallevy, 2015). England and Wales, where this study is based, primarily uses mental health law to manage this group. The term 'mentally disordered offenders' is used by the Crown Prosecution Service to describe those who are judged to have, "a disability or disorder of the mind", who have committed or are suspected of committing an offence and who have been given a hospital treatment order (Crown Prosecution Service, 2017). In cases where an offender is not diverted from custody, a judge must decide on the degree to which they are responsible for their actions. Statutory law and case law has evolved since 1843 to allow offenders with mental health problems to be judged 'not guilty by reason of insanity', be seen to have 'diminished responsibility' for a homicide or be judged 'unfit to plead' and therefore unable to contribute toward their own defence (see Fennell, 2013). Courts can choose to deal with these individuals through the criminal justice system where they view this as the most appropriate option. Research indicates that mentally disordered offenders have a similar offending profile to offenders in prison mental health wings, with more than a quarter of each group have been convicted for violence, property crime or acquisitive offending (Thomas et al, 2007). However, those given a hospital order are significantly more likely to have been convicted of a violent offence at point of trial, although are less likely to have been convicted of a homicide. Qualitative evidence indicates that judges are likely to use a hospital order under section 37 of the Mental Health Act 1983 (as amended by the Mental Health Act 2007) (MHA) (DOH, 2007) where offenders are judged by medics to be mentally disordered, where the offence is serious and where the statutory criteria are met (Qurashi and Shaw, 2008). Where judges believe the severity of an offence warrants extra steps being taken to protect the

public, they may impose a restriction order under section 41 of the MHA. The effect of a restriction order is to make the Ministry of Justice (MOJ) responsible for decisions relating to leave, discharge and community supervision. In these cases, a Responsible Clinician (normally a psychiatrist) is required to submit reports to the MOJ charting patient progress. Decisions by the MOJ are informed by these reports.

Whilst a hospital order may absolve an offender of criminal responsibility, progress through the forensic mental health system (which provides inpatient care for mentally disordered offenders), is controlled by mental health professionals including psychiatrists, psychologists, nurses, social workers and occupational therapists. Professionals from these disciplines contribute to care planning meetings at which patient progress is monitored. Discharge decisions are either made by the MOJ or a Mental Health Tribunal made up of a legal member, a medical member and a lay member. Whilst psychiatric perspectives dominate within the forensic system, the views of other professionals inform discharge decisions. There is, however, no clear consensus amongst professionals about how progress should be measured with different professions giving emphasis to medical, social or criminogenic risks (Davies et al, 2006).

Narratives are used by individuals in order to make evaluative statements about the self. Such evaluations draw on categorical identities, which are analogous to roles in society, such as parent, worker or spouse (Presser, 2008). As such, narratives may be viewed as moral statements in which individuals reflect on how far they have fulfilled social obligations. Offenders with mental health problems have to develop narratives which account for their reasons for offending, with an awareness of the different ways in which others may view their motivations and behaviours. The purpose of this article is to focus on the narratives of offenders' s subject to section 37 / 41 MHA

1983 as a means of highlighting how illness and offending are presented within talk to present a moral identity. I offer a new approach towards the study of offender narratives through drawing on theories from both the sociology of health and illness and criminology to identify how accounts of offending and illness intersect.

### **Offender and Illness narratives**

Studies of narrative within the sociology of health and illness have focussed on how language is used to present reality. Work by Kleinman (1988) and Frank (1995) has given particular focus to patient 'voice' outlining how illness is understood within lay accounts. As such, these theories demonstrate how patients may draw on or resist dominant social discourses. For example, Frank outlined that patients may give 'restitution' narratives, which reflect dominant discourses within medicine of diagnosis, professional treatment and recovery. Alternatively, they may give 'chaos narratives', which lack a coherent structure or 'quest narratives' which aim to identify meaning beyond medical constructs. Whilst such theory is useful in considering responses to illness, less attention has been paid to how individuals manage the moral dimensions of illness. As Bury argues it is important to explore how narratives move beyond themes of cause and effect (or lack of them) in order to explain how "sufferers seek to account for and perhaps justify themselves in the altered relations of body, self and society brought about by illness" (2001, p. 274). One reason that individuals may feel the need to justify themselves in this way is that illness identities are commonly stigmatised leading to the need to present 'moral tales' accounting for these (Blaxter, 2004). Individuals may seek to present as normal, despite physical pain, because they feel a moral imperative to fulfil social roles (Rosenfelt and Faircloth, 2004). Alternatively, those unable to fulfil such roles may justify their dependence on others through highlighting physical or emotional limitations caused by illness (Owen and Catalan, 2012). In giving these accounts individuals draw on common societal understandings about what it means to recover from particular types of illnesses. These may include

expectations that one will access appropriate treatment, remain resilient in the face of illness or seek not to inconvenience others (Rosenfelt and Faircloth, 2004; Owen and Catalan, 2012). In other words, narratives of illness and treatment are formed with social expectations in mind.

Criminology has developed different perspectives on how individuals give moral accounts. Theorists from interpretivist perspectives have examined how offenders take or avoid moral ownership for offending through talk. Such research has examined how offenders may use 'neutralization techniques', to deny or minimise responsibility for an offence. This may be achieved through denial of responsibility, denial of injury, denial of the victim, condemning the condemners or through appealing to higher loyalties (Sykes and Matza, 1957). Alternatively individuals may outline 'desistance' strategies through which they highlight how they have built lives as non-offenders (Maruna, 2001). Narrative criminology has extended this work through studying how language is used by offenders to present themselves as moral. For example, violent offenders may give reform narratives, accounting for their return to a previously good identity; stability narratives, in which they portray themselves as consistently moral or elastic narratives in which contradictory or vague accounts are given and in which desistance strategies are poorly formulated (Presser, 2008). In addition, offenders may seek to portray offences as excusable through referring to sub-cultural codes (Brookman et al, 2011) or through comparing themselves favourably to other offenders (Hochstetler et al, 2009). Narratives may also be used to draw on normally stigmatising labels, such as a diagnosis of Attention Deficit Hyperactivity Disorder, in order to provide a context or explanation for offending (Berger, 2015).

People subject to section 37 / 41 of the MHA 1983 are individuals who have been identified by the courts as both offenders and as people suffering from a mental disorder. As both offending and

illness can be understood as stigmatised identities individuals might be expected to present 'moral tales' that account for these. Previous research has gone some way to identifying moral justifications given by this group. Illness explanations dominate and are used by offenders to highlight a loss of ability to think and act rationally at the time of the offence (Askola et al, 2015; Coffey, 2012; Ferrito et al, 2012; Haggård-Grann and Gumpert, 2005). In his research, Coffey (2012) noted that illness served as an 'excuse' (Scott and Lyman, 1958) for offenders with mental health problems in enabling them to identify their offence as morally wrong, whilst not taking full responsibility for it. Additionally, research shows that a range of other explanations may be used to explain offending, namely drug and alcohol misuse, a previous criminal lifestyle or being victimised by others (Askola et al, 2015; Ferrito et al, 2012; Haggård-Grann and Gumpert, 2005). Whilst current papers identify that both illness and environmental factors may be cited by offenders with mental health problems to justify offending, there has been little attention given to the extent to which these explanations inter-sect. Furthermore, the extent to which different positions towards illness are associated with different types of moral accounts remains unexplored. The findings presented in this paper focus on these issues.

## **Methodology**

### Sample

The inclusion criteria for the study was that participants were subject to section 41 MHA 1983. This meant that all participants had been identified at trial as mentally ill and that treatment and aftercare subject to MOJ restrictions had been deemed necessary for the protection of the public. Potential participants were excluded if they were due to be recalled back to hospital, were identified by their care co-ordinators as experiencing undue distress or if I had been involved in their care (I had previously worked as a social worker in a forensic unit). A maximum variation sampling strategy (Bryman, 2012) enabled me to sample a range of participants by gender, ethnicity and offence type.

Potential participants were identified through Mental Health Act administrators and Team Managers within each area. In order to maximise the sample, a number of steps were taken. Information sheets were given to participants via their social supervisor (the health or social care professional responsible for their supervision in the community). This explained the purpose of the study, gave information about the researcher, explained the potential risks and benefits of taking part and indicated that a £20 payment would be paid. In instances where individuals agreed to be contacted, I made telephone contact and gave a further verbal explanation of the study. At the request of the NHS ethics committee, a seven day 'cooling-off' period was given, after which a further telephone call was made. Where consent was confirmed a reminder letter was sent giving details of the interview. Thirty eight individuals were approached of whom 22 initially agreed to take part, with 19 (50%) agreeing to take part after the 'cooling-off' period. The majority of participants did not give a reason for their refusal. Where participants did give a reason (to me or their supervisors) three stated that they were tired of discussing their offending histories and one stated he was too busy to take part. Participants were informed that interview data would remain confidential unless they revealed that they planned to harm themselves or others; raised child safeguarding concerns or gave information about a serious offence not already on record. Participants were also asked if they would be willing for the researcher to access their health and social care records to access risk information about them. All participants gave signed informed consent and were willing to allow the researcher access to their records. The gender balance of participants, where 2 (11%) were female and 17 (89%) were male, was equivalent to the restricted patient population between 1998 and 2008 where 11-13% were female and 87-89% were male (MOJ, 2010). All participants fell within the 21-59 year old age bracket which accounted for 89% of admissions recorded by the MOJ in the same period (*ibid*). MOJ statistics do not record service user ethnicity or offence type. However, research by Coid *et al* (2000) indicates 74% of admissions to high and medium security are white, 21% black, 3% Asian and 2% other. The ethnic mix of participants in this study was similar with 15 (79%) being



white and 4 (21%) being black. Information about participants' age, gender, ethnicity, offence and legal status are given in table 1.

[Table 1 here].

### Data Collection

The research was conducted between March 2009 and September 2011 in three mental health trusts in the South of England. Ethical approval was granted by the National Health Service Research Ethics Committee and favourable opinion was also received from each health trust.

There is lack of agreement amongst narrative researchers on whether interviews focussing on narratives should remain unstructured or not (Cohen, 2008). Within this project I adopted a semi-structured format. I asked participants how they had come to be placed on section 41 MHA 1983. I asked for their opinion of why others might have felt that it was necessary as well as for their own views on the process. I also asked them to discuss the purpose of the restriction order, their subsequent conditions and the degree to which these structures affected their interactions with others. I used non-verbal cues and interpreting questions (Kvale, 1996) to encourage participants to expand on their answers and to check my understanding was correct. The length of interviews varied with the shortest being 20 minutes and the longest being 100 minutes. Interviews were recorded and later transcribed by a professional transcription service.

### Analysis

Transcripts were initially coded on paper and the codes entered into Nvivo to aid organisation of these data. I used a 'code and retrieve' method to identify common phenomena, collect examples of these phenomena and to identify common themes and patterns within these data as well as exceptional cases (Siedel and Kelle, 1995). In conducting my analysis I aimed to examine both what I was told and its function (Coffey and Atkinson, 1996). Thus, the analysis focussed particularly on

the discourses individuals adopted to discuss both offending and illness and the degree to which these intersected. In presenting participant narratives, I have been mindful of criticisms made against narrative research by Atkinson (2009). That is, the temptation for researchers to prioritise dramatic accounts over plain ones. Consequently I have focussed on both plain and dramatic descriptions and the degree to which these are used to do moral work.

## **Findings**

Participants' position towards illness formed a central part of all narratives. In the following section I set out these different positions and how they affected explanations of offending.

### Acceptance of illness and treatment as a moral reform strategy

A first group of participants offered narratives which highlighted how they accepted a diagnosis of mental illness as an explanation for their offending and were morally reformed through treatment or rehabilitation. Moral reform in these cases was associated with a range of treatment or behavioural strategies which might enable them to return to a previously good identity. These narratives were offered by nine individuals within the sample. Towards the beginning of interviews I told offenders that I was interested to find out how they came to be subject to section 37 / 41 MHA 1983.

Participants in this category responded to this question by offering narratives in which their legal status as mentally disordered offenders was highlighted. For example Neil gave the following account:

Neil: His [the judge's] words were, 'I can see what clearly went wrong...'

Interviewer: Right.

Neil: '...You need to be hospitalised'...

Interviewer: OK

Neil: "...and I'm giving you a section 37 / 41'.

In line with others in this group Neil drew on the words of an authority figure to support his claim as an offender with a mental health problem. The statement by the judge was used to highlight that he had not been at fault for the offence because he had been diagnosed as mentally ill and was in need of treatment.

Although individuals in this group identified themselves as ill this did not mean that they discussed the nature of that illness in detail. Two participants named their diagnoses as paranoid schizophrenia and depression, whilst others referred more generally to 'mental illness' or 'illness'. Within narratives, illness was positioned as a biological disorder that might affect anybody. Illness was identified as something that might overwhelm an individual, leading to a loss of rational thought. Because it was seen as beyond an individual's control it was cited as a form of mitigation for offending. For example Adam stated:

"I'm just a guy who got ill and did something stupid that I wouldn't have done in my right state of mind".

Whilst illness was used by participants to explain the offence, moral reform was described in two ways. A first group, made up of five participants, focussed on the need to accept treatment. Within these narratives individuals identified accepting professional intervention as being central, even where the nature of the illness was poorly defined. These narratives focussed on how individuals had worked with mental health staff to identify treatment plans. Some participants described co-operating with mental health staff from the outset, whilst others indicated that they had learnt the importance of co-operation over time. In both cases, psychiatric treatment was identified as a central strategy for avoiding future offending. For example, when asked to reflect on the likelihood of offending in the future Richard said:

"I think now because I am taking the medicine I am calmer now so I won't be committing any crimes and won't be taking drugs. It is because of the medication I'm taking".

Participants in this group positioned taking medication as the principle way of avoiding future offending on the basis that it controlled the symptoms of their illness. However, these explanations also acted to shield them from examining their offending behaviour more broadly. For example, in Richard's case, the impression was given that biological illness had been directly responsible for his offending behaviour. However, when questioned further he identified that he believed that had been unwell for three years and that his offending behaviour dated back "ten to fifteen years" and included a serious assault, leading to a prison sentence.

A second group, made up of three participants, described moral reform in more complex ways. Whilst these participants accepted that they had suffered from an illness, their narratives differed in that alternative explanations to illness were also highlighted and explored. For example, Michael highlighted a range of factors that might lead to offending including his housing situation, boredom, experiencing racism from others and poor relationships with medical and social supervisors. As a consequence of this, strategies aimed at avoiding re-offending that were named by this group were also broader. Moral reform for these participants was seen to rely not only on support from mental health services, but also on housing stability, regular activity, and support from family.

### Contradictory accounts of illness

Three participants in my sample gave narratives in which concepts of illness were used in contradictory ways. There was no overlap between participants in this group and those in other categories. In line with those describing moral reform through treatment, these participants focussed on how others came to identify them as mentally ill and how illness reduced responsibility for offending. However, these participants did not use illness explanations consistently. These inconsistencies were demonstrated in two ways. First, one participant denied that he had been ill, but later used illness as mitigation. Ian said:

“The first time they [mental health professionals] said I had a psychosis or schizophrenia but I never believed that. I never hear voices or had hallucinations and I wasn’t psychotic. It was because I was informing on paedophiles at the time...and they tried to attack me...”

Despite indicating that he had never heard voices or experienced hallucinations, Ian went on to use illness as mitigation when referring to a later incident where he had threatened four people with a knife. Whilst dismissing the incident as “a joke” Ian also raised psychosis as a possible explanation saying:

“Maybe I was psychotic again. Cannabis makes me ill, makes you hear voices and hallucinate”.

Here, Ian moved away from using the personal pronoun ‘I’ when describing the effects of cannabis, stating that cannabis “makes you hear voices and hallucinate”. The use of more impersonal language when describing psychotic symptoms acted to distance him from the label of illness, as drug-induced psychosis was presented as a general effect of the drug. Second, two participants stated that they were ill at the time of the offence, but went on to question this later in the narrative. Lamal used a diagnosis of mental illness to explain his assault on a police officer, noting that he had not been “in his right mind” and “mentally ill”. However, he went on to say:

“Yeah, but the police officer one [offence] I was not thinking because all I wanted to do that day was to go to my brother’s house and plus they [hospital staff] gave me drugs. And when you’re on drugs, their drugs, their medication, yeah, it’s paranoia when you’re outside. Because, when you get addicted to it, yeah, it becomes paranoia when you need their drugs”.

In this narrative, illness was seen to arise *from* psychiatric treatment, with mental health professionals being seen as responsible for the offence through enforcing it. By contrast Daniel argued that he had been ill at the time of the offence, but went on to question whether treatment had actually affected his recovery, noting that he had only been made subject to a “small dose” of

medication. Within the narratives of these participants illness was used to mitigate their responsibility for offending, although professional definitions of illness were also questioned. Whilst this produced narratives that were contradictory, the narrative techniques allowed participants to claim mitigation for offending whilst rejecting stigmatising labels of illness.

### III but dishonourable Identities

Two participants in my study described having dishonourable identities. These participants were aware that they had been diagnosed as mentally ill but were distinct from the previous two categories of participants in that illness was cited as affecting their behaviour but was not used as mitigation. Whilst they acknowledged that a label of mental illness might provide mitigation in the legal sense, they continued to present themselves as dishonourable people. Both individuals identified themselves as having continuing urges to hurt others. Sally described an ongoing fantasy to harm others with knives. She had handed in a number of knives to her mental health team, but reported that she continued to carry them, although she would leave them in her car when going to the health centre. She said:

“It’s a comfort if you have a knife. It’s not to protect myself, not that sort of comfort. It’s a power thing as well. I can do this [stab people] and you can’t stop me”.

Her continuing fantasies to harm others were outlined throughout the interview. She also highlighted an ongoing wish to harm herself. Thus, a label of illness was acknowledged by Sally, but was not seen to mitigate against the stigma of offending due to the limited effects that she believed the treatment had. In addition, participants in this group believed that certain types of offences were so serious that illness did not serve to reduce the effects of stigma. Oliver, who had a history of sexual offending against children said:

“It’s like when you do something extremely wrong, dangerous; you hurt children, that aspect. That’s the low of the low thing in the eyes of the public. Forget murder, arson

anything like that. Crimes against children is the low of the low, the bottom of the heap.

That's how I look at it and that's the way society sees it".

Thus, whilst receiving and accepting a diagnosis, Oliver gave prominence to the stigma of being a paedophile throughout his account. Furthermore, his narrative highlighted that he had internalised dominant social values about sexual offending.

### Rejection of illness

Within my sample, five participants rejected a diagnosis of mental illness in their narratives. For this group, illness was not identified as something that might be presented in a benign fashion. Rather, it was viewed as something that threatened to permanently discredit their identity. For example, Frances complained about the content of a psychiatric report because:

"...it made me look a totally incompetent person totally being unable to know what was going on, that I was too mentally ill to know what was going on...."

As all individuals in this group rejected that they were ill, they needed to explain why professionals felt differently. Four individuals accounted for this through constructing their own definitions of mental illness and identifying how they compared to these.

In giving these explanations, they drew on medical language but questioned its meaning. For example Frances stated:

"...everyone's a bit mental in every sector and they gets panic attacks and aggravated. I don't get aggravated but some people do. I don't get irritable, I just get depressed. If I'm mentally ill then all it is is that I'm nervous and a bit of panic attack. I'm not psychotic, not [more] paranoid than anybody else, not [more] depressed than anybody else so really that makes me normal even when they're calling me mentally ill".

In giving this explanation, Frances referred to a number of common mental health problems such as depression and anxiety. He identified himself as suffering from these, thereby aligning himself with

members of the 'ordinary' population. In doing so, Frances attempted to downgrade the status of the label of mental illness that he had been given, but also noted problems with this. Within his account, he identified that mental health staff could force medication on individuals with a mental illness, despite them not being a risk towards others. A diagnosis of mental illness was thereby seen as something which might be viewed as normal but which might also pose problems, due to mental health laws which applied to the general population. In line with Frances' account the narratives of participants in this group had a moral purpose in establishing them as normal compared to the population as a whole. Additionally, such narratives were used by participants to highlight wider injustices within the mental health system.

Participants in this group sought to resist labels of mental disorder. However, this presented them with a dilemma. Progress through the forensic mental health system was seen by participant to be dependent on them admitting that they had a mental disorder as a prerequisite of discharge. Despite this, participants in this group chose to resist their diagnosis. For example Phillip identified that others within the hospital had encouraged him to fake agreement with mental health staff in order to achieve discharge. However, he stated that it "was important to maintain what I felt was real and the truth". Other participants in this category also gave accounts, in which telling the truth as they saw it, was a matter beyond negotiation. Within these accounts, participants highlighted how their continued position had led to mental health staff being more flexible in their approach. Phillip went onto say,

"The doctor said to me, Phillip, she said, as long as you understand what we're saying, that we think this [that you have a mental illness]...but you're saying another thing. As long as we understand each other's ideas then we can work together. Obviously you're really well and everything's going great so we can back you for a discharge".

Through maintaining their position that they did not have a serious mental health problem, participants identified that they had upheld their personal integrity. Whilst taking this position was



not without risk, participants identified the possibility that they might uphold their own definitions of why they had offended. In contrast to other participants, individuals in this category did not use a diagnosis of illness to mitigate against offending. They did however question their culpability in other ways. Individuals rejecting illness were clear that they had attacked others but sought to justify why they had done so. An exception to this was Vic, who stated that he could not remember his offence, although he expressed doubt that he had committed it. Three of the participants explained their offences through claiming that others had attacked them first, either verbally, physically or through taking property. Offences were therefore seen as self-defence. For example, Quentin claimed that a supermarket chain and the council [local government] had been trying to take items from his property with help from the police. He said:

“I threatened the police and I threatened the council and said if you come on my property and take my stuff I will maim one of you. And they chased me around and I went to beat one of the police up and the council official and they had me dragged away. [I] tried to stop them taking my stuff”.

Violence was therefore seen to be justified on the grounds that he was “doing what was natural” though defending his own rights and those of his family. Similarly, other participants in this group acknowledged their offences, but claimed that actions by others absolved them of blame.

### Discussion

The study had a number of limitations. The size of the sample was small due to those subject to section 37 / 41 MHA being a difficult to reach population and the refusal rate was 50%.

Nonetheless, my approach does offer a new way of viewing how offenders with mental health problems understand their offending behaviour.

Research into offender narratives has focussed on the degree to which they accept or reject responsibility for their offending. In line with other research participants, offenders use speech to position themselves as moral agents (Atkinson and Coffey, 2003, p.116). As offending carries a powerful stigma, offenders have to work hard to convince others that they have adopted desistance strategies or that the label that they have been given is unjust. Offenders who have been given a diagnosis of mental illness are doubly stigmatised in that they have been identified both as offenders and people who are mentally ill. As previous research has found, these individuals may use illness to justify or excuse offending. However, current research underplays the variety of positions that this group adopts towards illness. These positions are important because they impact on offenders' moral justifications for their actions and subsequent reform strategies.

In line with Coffey's (2012) research a group of offenders in my study highlighted mental disorder as their main reason for offending. A key aspect within narratives was how others had come to recognise that they had been mentally ill. In drawing on the accounts of doctors and judges, participants sought to establish normative frameworks through which their offending should be judged. Specifically, they drew attention to how mental disorder diminished legal responsibility. Descriptions of the trial and events leading up to it were used as a 'strategic device' (Hyden, 1997) to highlight that they belonged to a particular category of person, lacking responsibility for their actions. Illness was cited as a 'biographical disruption' (Bury, 1982), being used to explain a shift from a 'well' to an 'ill' identity. Whilst diagnostic descriptions were rarely used, plain descriptions of 'mental illness' or 'illness' were employed to signal agreement with medical models. Descriptions reflected either a 'broken brain' model (Andreason, 1984) or a bio-psycho-social understanding (Engel, 1989). In taking these positions participants signalled that their diagnosis was not a matter of choice being primarily biological in origin. Illness was therefore viewed as a phenomenon which suspended personal agency but which might be addressed through treatment. Having established legal mitigation, participants felt it necessary to account for how they had achieved moral reform

through identifying how they had recovered from illness. Summarising Cox (1976) Adshead et al have argued that recovery for forensic patients consists of, “a narrative shift from, ‘I didn’t do it’ to, ‘I did it but I was mentally ill’ to ‘I did it’” (2015, p.77). They theorise that this involves patients acknowledging illness, whilst taking responsibility for offending on the basis that psychotic beliefs may reflect deeper motivations. In contrast to these theories, participants in this category used illness to neutralize the stigma of offending (taking a, ‘I did it but I was mentally ill’ position). However, this did not mean that moral reform was seen as unnecessary by this group. These individuals provided what Presser (2008) has referred to as ‘reform narratives’, in that they outlined strategies adopted to return to a previously good moral self. However, in the case of the first group of participants who aligned moral reform with accepting treatment, these strategies were bio-medical in nature. Through using restitution narratives, this group signalled that they had accepted prescribed treatments and that this had led to a remission of symptoms. A return to a good identity was therefore firmly aligned with accepting treatment, in line with dominant professional narratives in forensic care (Davies et al, 2006). Furthermore, stopping treatment was connected to the possibility of relapse and a return to the ‘bad self’. The retention of personal agency was therefore seen to be dependent on psychiatric medication. Acceptance of medical treatment was associated with moral reform because participants believed it enabled them to make clear decisions about offending in the future. This emphasis on treatment was positioned by participants as making explorations of deeper motivations at the time of the offence unnecessary.

Whilst a second group of participants in this category described moral reform through reference to both medical and social factors, this reform was also heavily associated with medical treatment. Accepting treatment was seen as an important first step in moral reform in enabling participants to regain their agency. However, acceptance of treatment itself was seen as insufficient. Rather, participants identified the need to attend to interactional and structural reasons for offending through a focus on their personal relationships and social circumstances. Whilst restitution

narratives were used by some to signal a return to a moral self, descriptions of illness were not used consistently by all.

Frank (1995) has used the notion of 'chaos narratives' to describe stories by sufferers in which doctors are unable to understand their illness or to treat it effectively. Those using concepts of illness inconsistently here did signal a lack of faith in treatment. However, their narratives can be better understood as 'elastic narratives' (Presser, 2008) in that illness was used flexibly to launch claims and counterclaims about the moral self. In line with the first group of participants, individuals in this category used illness to signal that they were not morally responsible for offending. However, in contrast to that group, they also used additional neutralization techniques (Matza and Sykes, 1957). Participants denied injury through presenting threats to others as 'a joke' and condemned the condemners through describing forced medication as the reason for offending. These explanations were used to deny responsibility for the offence at points at which they denied or expressed ambivalent views towards illness. Whilst contradictory, these techniques enabled them to question whether they should take treatment as advised by doctors, in contrast to implicit social assumptions associated with restitution narratives.

Whilst illness may be used to mitigate responsibility for offending, this strategy is not used universally by all. In relation to sex offenders, Hudson (2011) notes that offenders are prone to mirror the views of wider society, placing offenders in a hierarchy with sex offenders at the bottom. In a similar way, participants giving ill but dishonourable identities referred to either offending or illness hierarchies, placing themselves at the bottom. In Oliver's case, his identity as a paedophile was then seen to invalidate claims that illness might mitigate responsibility for offending. These views drew on opinion from both professionals and patients who had questioned his place in the system. In line with these views, he categorised himself as immoral. In addition, both participants in

this category identified themselves as suffering from a personality disorder. This diagnosis has been identified as stigmatised within the mental health system, due to beliefs by some psychiatrists that medical treatment is ineffective for this group (Sulzer, 2015). Participants in this group showed an awareness of the status of their diagnosis and also shared the view that treatments for the condition were ineffective. Consequently, they did not view treatment as a route through which they could return to a good self.

Previous research into the narratives of offenders with mental health problems has focussed on the way that they use illness to reduce the stigma of offending. However, this research has largely neglected offenders who might reject a label of illness. In some senses this is surprising, as narrative research has highlighted that individuals may resist diagnostic labels for some time. Individuals may resist psychiatric diagnosis because they reject mental illness as a concept, because they believe that their diagnosis does not fully describe their experience or because they wish to avoid the stigma associated with mental illness (Cohen, 2008). Subsequent resistance may be demonstrated through increased personal assertiveness or through political activism (Gray, 2001). Resistance does, however, carry certain dangers for those subject to section 37/41 MHA because the order is designed to function as a social control measure. Coercive mechanisms within mental health policy can be viewed as a form of 'normalisation' in that they are designed to encourage patients to internalise dominant values about health. Resistance by service users may therefore be interpreted as evidence of 'non-compliant' or 'risky' behaviour by mental health staff which may lead to the use of further controls. Service users may therefore regulate how they communicate with staff or may display resistance in subtle ways in order to be assessed as 'low risk' (Coffey, 2011; Reynolds et al, 2014). Participants in my research however, were more overt in their resistance to professional perspectives. Those rejecting a diagnosis of mental illness in my study associated mental illness with incompetence or violence and believed that others viewed it similarly. Whilst they acknowledged that they had received a diagnosis, they sought to use what Thoits (2011) refers to as 'deflection

techniques' to limit stigma. They did this through defining their problems in terms less stigmatising than their perceived image of mental illness. Specifically, they portrayed themselves as having experienced distress but associated this with either the pressures of everyday life or the actions of mental health staff. This then affected their narratives of offending. Those within this category all gave what Presser (2008) has termed 'stability narratives', in which they presented themselves as having a consistently good moral identity through life as a whole. In order to maintain this stance, this group used common neutralization techniques to explain their offending. In taking this position, participants saw themselves as maintaining moral integrity. However, in line with offenders subject to section 41 in Coffey's (2011, 2013) research, these offenders recognised that challenging the system had particular costs. Specifically, participants saw resistance as having lengthened their time in hospital and also recognised that it might lengthen supervision in the community. Nonetheless, these actions were seen to have prompted a degree of accommodation by mental health staff who were forced to work around these narratives.

## Conclusion

People identified by courts as 'mentally disordered offenders' are seen as both patients who need to be treated and as offenders who need to be managed. Before release, offenders are required to give accounts about how they have recovered from illness and how they will avoid future offending. This article has added to previous knowledge through identifying how the different positions offenders diagnosed with mental health problems hold towards illness are used to reflect a moral identity. In line with previous research, the majority of participants in this study used illness to reduce responsibility for offending. Closer attention to these narratives reveals that two different positions may follow on from this. First, individuals may signal compliance with treatment as a central reform strategy. Second, they may use concepts of illness in an elastic way to both mitigate responsibility for offending and to question their own obligation to engage with treatment. However, a diagnosis of illness was not used to excuse offending by all. A third category of

participants identified themselves as being immoral due to both the type of offence that they had committed and their diagnosis. A final category sought to define themselves as moral through seeking to explain their offending as justified whilst also rejecting a diagnosis of mental illness.

A number of issues might be addressed through future research. Criminological research has identified that female offenders are more likely than men to relate their offending to domestic incidents or power imbalances (Jack, 1999). As only two participants in my research were female, it was difficult to draw conclusions from their accounts. However, further research focussing on female offenders with mental health problems has the potential to reveal a different set of narratives. Furthermore, it is worth noting that the participants in this study had been treated within the forensic mental health system for long periods of time. Prisoners with mental health will be subject to different discourses about rehabilitation and treatment. Narrative research conducted with this group may reveal different themes due to the group being less likely to have committed a violent offence at point of trial (Thomas, McCrone and Fahy, 2009) and also due to different rehabilitative ideals within the prison system. The findings are of relevance to the forensic mental health system. Narratives identify people's beliefs towards their circumstances. In addition to providing explanations for action, they also identify strong ideals which infer patterns of action and behaviour at group levels (Cohen, 2015). As the forensic mental health system is concerned with moral reform, it is important for professionals within the system to understand how offending may be justified by users within these settings. This research indicates that whilst an acceptance of illness was felt to be useful by some participants, it also acted to limit reflection in some cases. However, it also indicated that many offenders refer to illness in flexible ways or do not use it to justify offending at all. This indicates that a broader range of strategies need developing to enable offenders with mental health problems to consider their actions and how they might avoid offending in the future.

Table 1 - Details of Participants

<b>Pseudonym of Participant</b>	<b>Gender</b>	<b>Age</b>	<b>Ethnicity</b>	<b>Index Offence</b>	<b>Legal Status</b>
<b>Adam</b>	Male	35	White UK	Manslaughter	Conditional discharge
<b>Ben</b>	Male	39	Black British	Assault and Actual Bodily Harm	Conditional Discharge
<b>Christopher</b>	Male	53	White UK	Actual Bodily Harm	Conditional Discharge
<b>Daniel</b>	Male	59	White UK	Manslaughter	Conditional Discharge
<b>Eric</b>	Male	40	White UK	Arson	Deferred Conditional Discharge (after having been recalled from a Conditional Discharge)
<b>Francis</b>	Male	45	White UK	Actual bodily harm and criminal damage	Conditional Discharge
<b>Grace</b>	Female	45	White UK	Arson	Conditional Discharge
<b>Henry</b>	Male	55	White UK	Arson and burglary	Conditional Discharge
<b>Ian</b>	Male	36	White UK	Actual bodily harm	Detained under section 37/41 MHA 1983 (after having been recalled from a Conditional Discharge)
<b>Lamal</b>	Male	26	African	Actual Bodily Harm	Detained in hospital under section 37/41



MHA 1983.

<b>Michael</b>	Male	52	African-Caribbean	Manslaughter	Conditional Discharge
<b>Neil</b>	Male	38	Black British	Manslaughter	Conditional Discharge
<b>Oliver</b>	Male	49	White UK	Legal category of offence missing from file, although professional reports make reference to a 'sexual offence'.	Conditional Discharge
<b>Phillip</b>	Male	31	White UK	Malicious wounding	Conditional Discharge
<b>Quentin</b>	Male	47	White UK	Actual Bodily Harm	Conditional Discharge
<b>Richard</b>	Male	34	White European	Wounding and Grievous Bodily Harm	Conditional Discharge
<b>Sally</b>	Female	39	White UK	Affray and Criminal damage	Conditional Discharge
<b>Tony</b>	Male	35	White UK	Common assault	Conditional Discharge
<b>Vic</b>	Male	36	White UK	Actual Bodily Harm	Deferred Conditional Discharge

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